Michigan Consumers for Healthcare

Why Should MI Adopt a Healthcare Exchange?
Testimony of Don Hazaert, Director, MCH
House Health Policy Committee
November 3, 2011

Chairwoman Haines and committee members, thank you so much for inviting the Michigan Consumers for Healthcare coalition to speak with you today. I am Don Hazaert, director of MCH which is a consumer-focused healthcare advocacy community consisting of over 90 organizations statewide. Joining me today are several of our Coalition's top policy experts: Jan Hudson with the Michigan League of Human Services, Tameshia Bridges with PHI (formerly Para-Professional Health Institute) and Jane Caplinger with the American Cancer Society.

We all know there have been some very strong feeling expressed around whether or not Michigan should create a healthcare exchange, as required under the federal Affordable Care Act. The rhetoric, at times, has become red hot. But thankfully we have had leaders like Governor Snyder and Senator Marleau step forward and work to douse those red hot embers just long enough to allow us to refocus the conversation back onto the actual healthcare consumer.

Our intention today is to offer more light then heat; to provide context, facts and the information you need to develop a healthcare marketplace that works for Michigan consumers. I will begin with the unenviable task of tackling the eight hundred pound gorilla in the room- the individual mandate and the Massachusetts exchange model.

The father of the individual mandate is conservative economist- and former policy advisor to President George H.W. Bush- Mark Pauly who advocated for the adoption of a universal healthcare proposal that would keep government from eventually taking over the healthcare sector. It is important

for conservatives to remember, that the individual mandate was not conceived as some form of creeping socialism but rather as a conservative, market-oriented alternative to what was seen as the eventual inevitability of a truly government run single-payer system in America. And this is hardly an irrational position since every other Western industrialized nation has some form of government-sponsored healthcare system.

In his original strategy memo, Pauly wrote, "Our view is that excessive government intervention will make matters worse… Our strategy, therefore, is to design a scheme that limits governmental rules and incentives to the extent necessary to achieve the objectives," In an interview conducted just this year, Pauly added, "We did it because we were concerned about the specter of single payer insurance, which isn't market-oriented, and we didn't think was a good idea."

In the early 90s, the individual mandate was adopted and promoted by the conservative Heritage Foundation. They dubbed it a "Health Care Social Contract" and wrote, the "central element in the Heritage proposal is a two-way commitment between government and citizens. Under this 'social contract' the federal government would agree to make it financially possible, through refundable tax benefits or in some cases by providing access to public-sector health programs, for every American family to purchase at least a back package of medical care including catastrophic insurance. In return, government would require, by law, every head of household acquire at least a basic health plan for his or her family."

This concept of mandated private insurance as an alternative to government run healthcare was supported by other conservative think tanks including Newt Gingrich's own Center for Health Transformation. Bob Dole and many Congressional Republicans, as you may recall, also embraced the concept as an alternative to what conservatives dubbed at the time HillaryCare. Dole even later made the mandate a campaign issue in his run for the presidency.

So when people refer to "they" or to "those people" who brought us the individual mandate, whether they realize it or not, they are actually referring to some of the leading conservative minds of the last two decades. Now I

realize that the dynamics of partisan politics- particularly presidential politics- has flipped this relationship somewhat on its head in the last few years but there still remains no reason a conservative lawmaker should shy away from what is fundamentally a well-conceived, market-oriented alternative to single payer.

Recently, of course, Massachusetts Governor Mitt Romney gained notoriety as the first governor to successfully implement this concept into what is now known as the Massachusetts exchange model. And it is that groundbreaking initiative that really brings us here today.

Now that we have defined what the Massachusetts model is not- namely, it is NOT the offspring of some left-wing conspiracy to move America ever one step closer to socialism- it is important to define what the Massachusetts model is. And what the Massachusetts model is, in my opinion at least, is the most successful public health initiative in this country in decades.

Today, in Massachusetts, 98.1% of the population has healthcare coverage. Contrast this with a national uninsured rate of 15.4%. I would ask you to ponder for a moment the innumerable benefits, financial, societal and otherwise, of moving a society from where more than 15% of us don't have access to a family physician to where fewer than 2% have no access.

The healthcare exchange created in Massachusetts, known as the Connector, has been remarkably successful in bringing costs down within the individual insurance market. According to FactCheck.org- a non-profit dedicated to cutting through the partisan spin to the essential facts of a policy debate- insurance policies sold on the Connector exchange have come down an average of 18 percent. Some policies have come down as much as 40 percent. To quote Factcheck.org, "any way you want to look at it premium costs came down."

FactCheck.org determined that virtually all of the partisan fear mongering around the Massachusetts exchange is unsupportable by the data. The program is not unpopular- public support rests at about 67% among non-seniors. Quality of care did not diminish and there were no delays in seeing

physicians. There was no taxpayer revolt- as some suggested would happen- and no dumping of employees by employers onto the exchange. Aside from lingering difficulties in making their small business exchange work properly, there were few obvious flaws.

In fact, the Massachusetts Taxpayer Foundation, that state's conservative counterpart to our own Mackinac Center, when so far as to publish their own paper debunking the myths that out-of-state politicians, partisan groups and think tanks were spreading about the Massachusetts model. Their essential message, get your facts straight.

SB 693, Sen. Marleau's bill to establish the MiHealth marketplace here in Michigan, currently in Senate Health Policy, is an excellent piece of legislation that conservatives and progressives alike can get behind. Conservatives can feel good that the bill uses no state dollars for the administration of the Exchange, creates no new state bureaucracy, and that it is entirely entrepreneurial in that it requires the MiHealth marketplace to survive on its own merits. Progressives, likewise, can feel good that the bill is also strongly pro-consumer in that it bans the insurance industry from sitting on the governing board of the Exchange and requires tough conflict of interest policies.

The first time I spoke before this committee earlier this summer, I reminded you that "what one state can do, another can do." The challenge before this Legislature, therefore, is to develop a consumer-focused marketplace that can compete with the level of success consumers in Massachusetts have been enjoying for several years now.

But with key stakeholders at the table- and having the luxury of learning from Massachusetts successes and failures- there is no reason that the MiHealth marketplace cannot rival any other state exchange for affordability, access, competition and transparency.

With that, I would like to turn things over to my colleague Jan Hudson from the Michigan League of Human Services who is going to be talking about the consumer populations that will be served by the MiHealth marketplace.

The Detroit News www.detnews.com

November 2, 2011 http://detnews.com/article/20111102/OPINION01/111020322

One-stop site for health care needed

DON HAZAERT

Gov. Rick Snyder continued his leadership in improving the health of Michigan residents with his recent call for the creation of the MiHealth marketplace.

The MiHealth marketplace would be a website where Michigan consumers and small businesses could shop for the best health insurance plan for them and their families. Gov. Snyder rightly called for quick action, urging the state Legislature to approve this consumer service by Thanksgiving to protect Michigan's health care system from unnecessary federal intervention.

Senate Bill 693, introduced by Sen. Jim Marleau, R-Lake Orion, would create the competitive MiHealth marketplace in Michigan to give consumers more control, quality choices, and better protections when buying insurance. The MiHealth marketplace establishes an easy-to-use website similar to Travelocity or Orbitz — as well as a 1-800 call-in center — that would allow consumers to make real comparisons between plans to find the one that best meets their needs and budget.

The legislation is designed to foster competition among health insurance carriers, benefiting individual consumers and small businesses who traditionally have lacked the purchasing power of big businesses when it comes to health insurance. The MiHealth marketplace would help contain costs and maintain quality coverage while giving consumers information, access and control.

No matter how you picture the development of the MiHealth marketplace, state lawmakers would serve consumers well by approving SB 693.

If Michigan fails to create this essential consumer resource, the federal government will create the marketplace for us. All 50 states are now federally mandated to establish a health care marketplace. So here's our choice: Michigan stakeholders can work together to create the best marketplace for Michigan, or we can let the federal government create one for us.

Michigan also stands to lose millions of dollars in federal implementation grant money if the state continues to delay establishing this new health care marketplace. These funds are vital in allowing the state to bring on board the staff and expertise necessary to properly design the MiHealth marketplace and integrate the technologies necessary to make the exchange run properly for consumers.

A tremendous amount of work is yet to be done to get ready to enroll up to 1.2 million uninsured Michiganians who could be looking to access coverage via the MiHealth marketplace.

This important and time-sensitive legislation is pending in the Senate Health Policy Committee. Michigan Consumers for Healthcare joins Gov. Snyder in urging immediate passage of the bill.

Don Hazaert is director of Michigan Consumers for Healthcare, a statewide nonprofit coalition that provides a voice for health care consumers. Learn more at consumersforhealthcare.org. Email comments to letters@detnews.com.

The Heritage Foundation Backgrounder

No. 777 | The Heritage Foundation 214 Massachusetts Avenue N.E. Washington, D.C. 20002 (202) 546-4400

July 20, 1990

USING TAX CREDITS TO CREATE AN AFFORDABLE NATIONAL HEALTH SYSTEM

INTRODUCTION

Demands are growing for reform of America's health care system. To be sure, the quality of care available in the United States surpasses that of any other nation. Still, as many as 37 million Americans are without health insurance during at least part of any year. Millions more have insurance that pays for routine care, but would not cover the catastrophic financial impact of a prolonged, serious illness.

Even those with adequate insurance provided through their place of work face increases in out-of-pocket charges, or cutbacks in coverage for family members, as employers try to contain surging insurance costs. Insurance companies complain that physicians persistently order unnecessary tests and procedures. Physicians complain that insurance company officials are interfering with the practice of good medical care. The result: a $600 billion health care system with which nobody, it seems, is happy.

Disenchantment with the system has spawned several high level government task forces and commissions charged with finding ways to improve U.S. health care. The ideas being considered by these bodies are in three broad categories:

- **Social insurance** programs, based on the Canadian system. These would provide every American with universal access to a comprehensive package of health services, dictated and paid for by government and financed through taxation.
- **Employer mandates.** These would require all employers either to provide at least a standard package of health insurance to employees and their

families, or to pay into a fund to finance insurance for families not covered at the place of work. This often is referred to as the "play or pay" approach.

♦ **Consumer-based systems. In these, changes in the tax treatment of health care purchases would provide families with the funds to buy adequate insurance and medical care directly, rather than depending on their employer or a government program. Such a consumer-based proposal was unveiled last year by The Heritage Foundation.**[1]

In the vigorous debate between proponents of these rival proposals, questions are raised about each approach. Close examination of the Canadian system, for example, reveals not only that it holds down health costs by systematically rationing care, but also that costs have been controlled far less than commonly believed.[2] Similarly, the mandated employer benefits proposal has encountered strong opposition from businesses, who claim that it rapidly will escalate company health costs, prompting layoffs and undercutting U.S. global competitiveness.

Concerns also have been raised regarding the Heritage Foundation proposal. Examples: Are families typically capable of making informed decisions when purchasing health insurance or medical services? Would not insurance companies tend to compete only for healthy families needing fewer services, leaving higher risk families with enormous premiums to pay? Would Americans accept such a seemingly radical change in their health care financing system?

While these and others are legitimate concerns, they are fully addressed in the Heritage proposal. Indeed, the Heritage proposal is the only one advanced to date that would assure affordable access to health care for all Americans with little or no additional cost to the federal Treasury and with built-in, market-driven incentives to keep costs under control.

THE GOALS OF HEALTH CARE REFORM

While there are differences of opinion on the details of what an ideal health care system would achieve, four features are broadly accepted as goals of such a system:

1) The system should assure affordable access to adequate health care for all Americans.

---

1 . Stuart M. Butler and Edmund F. Haislmaier (editors), *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); see also Butler, "Assuring Health Care for All Americans," *Heritage Lectures* No. 218, October 2, 1989.

2 Michael Walker, "Why Canada's Health Care System Is No Cure for America's Ills," Heritage Foundation *International Briefing* No. 19, November 13, 1989.

The notion that all citizens should be able to obtain adequate health care services at reasonable cost to the family budget is the central feature of most Americans' picture of an ideal system.

2) The system should contain incentives to economize.

The rapidly rising cost of today's health system has led lawmakers to insist that any serious reform must contain strong incentives to economize and keep costs under control—without cost becoming a barrier to necessary care.

3) Government help should go mainly to those who need it most, as measured by income or medical condition.

Many socialist countries base their health systems on the doctrine that government should provide the same quality and quantity of care to rich and poor alike. In the U.S., however, it is generally accepted that the more needy a family is, in terms of the cost of necessary medical care compared with the family's income, the more governmental help that family should receive.

4) As far as possible, crucial medical decisions should be made by the patient and his or her physician.

In addressing such basic medical questions as whether a major operation shall be performed, or who shall perform that operation, or how much shall be done to save a baby born prematurely, most Americans feel that these decisions should be made as much as possible by the individuals directly concerned. It is they, it is broadly believed, who should have the right to weigh the benefits and the risks, with proper medical advice and with some attention to the costs involved. These decisions are not to be left to some distant official whose life is not on the line.

Why the Current System Does Not Reach These Goals

The current health care system does not achieve these or many other goals. Most of the uninsured, and even many of those with basic insurance, find they cannot afford certain necessary health services. Few would contend, moreover, that the current system promotes efficient use of medical services. It seems unfair to many Americans that affluent workers and top executives enjoy unlimited tax-free medical services through their companies, while low-paid workers in other firms have no company insurance, and get no help from the tax code to offset the cost of buying the most basic services or insurance. And there is growing anxiety that basic medical decisions are being made by distant government or insurance company officials, or in response to rules determined by such officials. Thus elderly Americans, for instance, fear they may be "dumped" by a hospital because the hospital considers the Medicare reimbursement rate to be too low; unionized workers strike against the attempts of company health benefits managers to limit coverage for families; mothers of newborn babies grumble that insurance companies refuse to cover more than three days in hospital after the birth.

These shortcomings of the system have a common root: the powerful, perverse incentives created by the tax treatment of health care spending. Under the federal tax code, company-provided health services and insurance plans are excludable from each worker's taxable income. For example, if a worker's compensation is an annual cash salary of $25,000 plus $3,000 in the form of a company-paid health plan, for a total of $28,000, that worker pays income and payroll taxes on only $25,000 of income. This makes the health plan, in effect, tax-deductible at the worker's marginal rate of tax. If the firm does not provide a health plan, however, the worker can only obtain tax relief to the extent that his family's health expenses exceed 7.5 percent of adjusted gross income, and then only if the family itemizes its tax return. Most self-employed individuals can claim tax relief on just 25 percent of their health insurance costs.

This tax treatment means that the lion's share of tax relief goes to higher-paid employees with generous health plans. Meanwhile, casual workers or those in small firms without plans, who tend to incur relatively high medical costs compared with their income, typically receive no tax relief at all. When these latter workers buy health insurance they must do so with after-tax dollars, and normally they must pay relatively high premiums for individual coverage. It is little wonder that so many of these workers and their families lack insurance.

"Free Fringe Benefit." The tax treatment of health spending also helps boost total health costs, encourages inefficiency, and provokes labor disputes. Company plans, for example, have grown rapidly in recent decades for understandable reasons: both management and labor have favored contracts that offer more compensation in the form of tax-free health insurance than in the form of taxable cash. This means that for most Americans, in terms of after-tax dollars, it costs less to buy health care than to buy other goods and services — even if both carry exactly the same price tag. The result: workers tend to demand far more, often non-essential, health services than they would choose were they to pay for them in after-tax dollars. In addition, many workers and their unions have pressed employers to include routine, minor services in health plans because that allows these services to be paid for with pre-tax dollars. By contrast, workers tend to be less inclined to press for insurance covering highly unlikely, but financially crippling, medical situations. Thus many American workers have very generous and expensive health plans, yet lack catastrophic insurance.

In the minds of most workers, these company-paid plans, like other fringe benefits, seem to be free — even though an employer rightly treats health insurance as part of the overall compensation. Thus there is little or no incentive for workers to curb their demands for health services or to question hospital or physician prices, especially if deductibles and copayments in the plans are small.

This has several effects. A lack of any real incentive to economize is, of course, a recipe for health care cost inflation, and indeed the cost of medical

care for years has been rising at roughly double the average inflation rate. This means, of course, higher prices for those who do not have company-provided insurance and consequently reduces their ability to obtain medical care. Meanwhile, corporate efforts to constrain rising health costs by increasing the employee's share of costs normally are strongly resisted by workers, who see these direct payments as a cut in pay, forcing them to pay in after-tax dollars for care that previously was "free." Bitter strikes over company attempts to scale back health benefits are an increasingly common feature of labor disputes.

Why Mandated Benefits or a Canadian System Is No Answer to These Problems.

Neither a mandate on all employers to "play or pay," nor a Canadian-style universal social insurance program would solve all these problems, or achieve the four basic objectives of an ideal health system. Moreover, in many important ways, each would be less attractive than America's current system.

Under employer mandates or a Canadian system the government would legislate a right of access to a certain level of health care, through the private sector in the first case and the public sector in the second. But to control total costs, various regulations would be imposed by bureaucrats to restrict that supposed right of access. Such regulation would be necessary because the illusion of virtually free care would encourage far more demand for services than companies or the government would be willing to pay.

Shortages and Rationing. Economists recognize that when services are free of change, or nearly so, and controls are placed on the total costs of providing the service, the result invariably is shortages and rationing. Recent studies of the Canadian system reveal that government cost control leads to rationing by waiting list and a pervasive system of physician price controls. This policy has limited significantly the availability of procedures and technology and has encouraged a rising number of Canadians to seek health care services in the U.S.

An employer mandate simply would shift the tab to business without correcting the underlying incentives that lead to the problems of the current system. Corporate health benefits managers would become the reluctant regulators of a business-financed national health service, caught between stockholders determined to check costs and employees with the legal right to demand services. Very likely the majority of frustrated employers eventually would follow the lead of some of today's business leaders who argue that corporations should not be expected to manage and finance a national health system, and that the job should be turned over entirely to government.

THE HERITAGE FOUNDATION PROPOSAL

Last year, The Heritage Foundation published a proposal to achieve universal access to affordable health care.[3] This proposal, unlike the Canadian system or mandated benefits, seeks to cool health care inflation and assure access by strengthening market incentives in health care and restructuring the tax treatment of health care spending. Specifically, the proposal calls for two major steps:

1) End the link between health care tax breaks and the place of work.

Under the Heritage proposal, the unlimited tax exclusion for company-provided health benefits would be phased out over several years. Thus, while companies could continue to provide benefits and count them as tax-deductible labor costs, the value of such benefits now would be included in the employee's taxable compensation. If the employer chose to reduce or eliminate the health benefits provided, he would be required by law to add the savings to each employee's paycheck so that the worker's total compensation would be unaffected.

Offsetting this change in the tax code, a new system of personal tax credits for family health spending would be introduced. Under this new arrangement, a family could claim a credit when filing its 1040 tax form. The credit would be available for both insurance and out-of-pocket costs. It also would be an "above-the-line" credit, so the family would not have to itemize its return to claim the credit. It would be refundable, meaning that if the credit exceeded the family's total tax liability, the taxpayer would receive a check for the difference from the IRS.

The credit would be based on the family's health and insurance spending compared with its income. Thus a 20 percent credit might be available in most instances, but may rise to 30 percent of medical and health insurance expenses if these costs exceeded, say, 5 percent of family income in a year; a 50 percent credit if spending reached 10 percent of family income, and so on. For very affluent families spending only a small proportion of their income on health, the percentage credit would be less than 20 percent, and perhaps phased out completely for those above a certain income.

2) Establish a "Health Care Social Contract."

The second central element in the Heritage proposal is a two-way commitment between government and citizen. Under this "social contract," the federal government would agree to make it financially possible, through refundable tax benefits or in some cases by providing access to public-sector health programs, for every American family to purchase at least a basic package of

3 Butler and Haislmaier, *op. cit.*

medical care, including catastrophic insurance. In return, government would require, by law, every head of household to acquire at least a basic health plan for his or her family. Thus there would be mandated coverage under the Heritage proposal, but the mandate would apply to the family head, who is the appropriate person to shoulder the primary responsibility for the family's health needs, rather than employers, who are not.

EFFECTS OF THE HERITAGE PROPOSAL

By no longer restricting tax relief for medical care to employer-provided plans, and by restructuring tax assistance to help those Americans most in need, the Heritage proposal significantly would improve the American health system. Among the most important effects:

1)Good health care not dependent on employers. Employees would be able to acquire health coverage for their families, and obtain government tax help to pay for it, wherever they happen to work. Casual or part-time workers, employees of small firms, or dependents of workers – those who comprise a major share of the uninsured – would receive a refundable tax credit based on health costs compared with income – exactly the same form of government assistance to buy health services as Americans working in large firms. Thus the Heritage proposal would solve much of the current uninsurance problem.

The Heritage proposal also would allow complete "portability" of a worker's health coverage, since it would no longer be tied to the place of employment. If a worker changes jobs, or has a spell of unemployment, he or she would not lose the insurance or have to change coverage, nor would his or her family face the possibility of exclusions for pre-existing conditions and similar insurance restrictions common today when a worker changes jobs.

2)Incentives to economize. Under the current system of employer-provided health benefits, if an employee decides to make sensible economies in his or her use of a health plan, the employer saves. Under the Heritage proposal, the employee pockets the savings. Thus Americans would have the incentive to "shop around" for the most economical health plan to meet their legal obligation and their other health care preferences.

This would reduce the rate of medical cost inflation by encouraging cost-consciousness and discouraging over-use of medical services. A family may choose a more restrictive Health Maintenance Organization (HMO), for instance, rather than a plan with an unlimited choice of physician and hospital, to save money for other things. Healthy families would have the incentive to buy coverage with a larger deductible than is typical today and pay directly for routine minor medical bills. Healthy families today have the incentive to press employers to provide first-dollar coverage and then to overuse the "free" benefits.

3)Budget neutrality. For most Americans, the way in which government currently provides financial help to obtain health care is by excluding the cost of company-based plans from the employee's taxable income.[4] This means the government foregoes tax revenue. The Heritage Foundation proposal would reallocate these revenue losses as refundable income tax credits. Depending on the design of the credits, the proposal could be budget neutral, or decrease tax revenues only slightly.

The Congressional Budget Office, in its annual review of possible budget savings, calculates that if the current tax exclusion for company-based plans were ended, and a 20 percent tax credit introduced into the individual tax code for health insurance costs up to $250 per month for a family ($100 for an individual in 1990 dollars), the government would collect an extra $89.4 billion in tax revenue over the next five years, or an average of $17.9 billion per year.[5] Thus if budget neutrality is a goal, the CBO figures suggest that this sum would be available to provide a refundable credit to those not now covered, and to give a more generous credit for those Americans facing high medical costs compared with their incomes.

The table that follows compares the implications for individual workers and their families of the Heritage plan, compared with current law, the mandated benefits proposal, and the Canadian system.

CONCERNS ABOUT THE HERITAGE PROPOSAL

While many lawmakers, physicians, and workers see the attraction of individual credits for health insurance, they also imagine there are various practical problems with such an approach. But these concerns either misunderstand the nature of the Heritage proposal, or they can be dealt with through small modifications of the basic approach.

Among the most common concerns:

1)Since medical care is such a complex product, can average Americans really be expected to make sensible purchasing decisions regarding medical care and insurance?

This concern overlooks the way in which competition and consumer choices actually would work in a reformed health care system. If out-of-pocket medical costs were given the same tax breaks as insurance premiums, more Americans would pay directly for routine minor services now often cov-

4 For the very poor, the state and federal government pays directly for approved care, veterans are covered under the Veterans Affairs health system, while most hospital care for the elderly is reimbursed through Medicare.

5 Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, (Washington, D.C.: U.S. Government Printing Office, 1990), pp. 145, 146.

HOW HEALTH REFORM PROPOSALS WOULD AFFECT WORKERS AND THEIR FAMILIES

	Current Law	Mandated Benefits	Canadian System	Heritage Proposal
Tax benefits to employee.	Unlimited company-paid services tax-exempt at marginal tax rate. No tax benefits for out-of-pocket costs.	Same as current law	All health care "free" and untaxed.	Individual tax credits, based on income and health costs, for insurance and out-of-pocket costs.
What if employee below tax threshold?	No special tax benefits.	Same as current law.	Irrelevant, since services are "free".	Tax credits are refundable.
Who decides basic package of services?	Company/union negotiators.	Government.	Government.	Government.
Who decides additional services?	Company/union negotiators.	Company/union negotiators.	Government.	Worker.
What if company does not provide health insurance?	Employee and family is uninsured or buys insurance and services with after-tax dollars.	All companies must provide family coverage or pay into government fund to provide coverage to uninsured.	Companies have no role in system.	Individual tax credits to buy family coverage — purchase of basic coverage mandatory for families.
Unhappy with health plan?	Complain to union or switch jobs.	Complain to union and government.	Complain to politicians.*	Change plans.
Switch jobs?	May lose certain benefits or become uninsured for existing conditions.	Basic package unaffected. Additional benefits may change.	Coverage unaffected.	Coverage unaffected.
Dependents not covered under plan?	Uninsured, or buy extra coverage with after-tax dollars.	Law requires family coverage by basic plan.	Everyone covered.	Head of household must, by law, buy basic family coverage. Tax credits offset cost.

*It is unlawful for Canadians dissatisfied with the quality of government-financed health services to purchase private insurance in Canada for these same services. Canadians may, however, buy private insurance or services in the U.S. or any other country.

ered by insurance, such as dental work, annual physical, eyeglasses, and treatment for minor injuries. In these cases the required medical knowledge is small, and consumer decisions would tend to be based on such issues as cost, waiting time, choice of doctor and other important, but non-technical factors.

Consumer choice would work just as well in buying insurance. Knowledgeable consumers carefully would select the plan providing the features they want at the most competitive price. Less knowledgeable Americans either would take the advice of an expert in whom they had confidence, such as their family physician or a consumer organization, or they could join a purchasing group that they felt would represent their interests.

2)Wouldn't individual insurance be more expensive than company-based group insurance?

Individual health insurance policies today generally are more expensive than company-based plans. This is mainly because administrative and marketing costs tend to be high when the market is small and potential buyers widely dispersed, as with today's individual insurance. But if individual buyers were the largest segment of the market, these overhead costs would fall, making individual coverage more competitive. It is likely under the Heritage proposal, however, that group insurance would continue to be the typical form of health coverage because groups could bargain most effectively with physicians, hospitals, and insurers. What would be different is that the group probably would not be composed of the employees of a particular company.

Today's tax laws make the place of work virtually the only group that Americans can join to have the bargaining power and the economies of scale to obtain affordable insurance. Under the Heritage proposal, by contrast, families could join other groups as the basis for insurance, with the group administrators perhaps charging a management fee.

Forming Groups. The group presumably would be an organization that the family felt would act in its interest, such as a union, a church, a group representing minority workers, or women business owners. It could also be a group of individuals with special medical needs, such as diabetics, needing plans with particular services. In each case the individual would gain the economies of scale and bargaining power of the larger group, and he or she could choose a group that arranged the desired package of insurance and services at the best price. Today a worker and his family normally must accept the plan services selected by the employer, whether or not they are ideal.

It is almost certain that a wide range of groups would emerge. One reason for confidence is that non-employer groups exist today even with only very limited tax breaks available. Examples: various state farm bureaus offer group plans for agricultural workers; in Washington, D.C., TANS/MED markets low cost plans for young workers without company insurance, such as full time babysitters; and a number of labor unions sponsor plans. Indeed, unions very likely would become major group managers under the Heritage proposal, offering good rates as a membership inducement.

The shift to a system encouraging consumer-driven choice and competition would reduce the general cost of insurance. Today's company-based insurance necessarily involves a considerable amount of costly paperwork because insurers and health benefits managers must try to regulate or restrict the use of medical care by families who have no natural reason to economize, given the nature of company-based plans. Under a market-based system, however, the user has strong incentives to economize, since he or she keeps the savings. Thus the bureaucratic controls of the current system would be replaced in large part by the "controls" of the market, reducing administrative costs.

3)But if such groups did form, wouldn't insurers compete for the lowest risk families? Wouldn't such "adverse selection" leave many Americans with prohibitively high premiums?

The problem of adverse selection is seen by many as a fatal flaw of a system based on individual selection, even if groups did form to buy insurance or bargain with providers for good rates. It is true that many insurers would compete for healthy families, leaving other families to choose from more expensive plans under the Heritage proposal. Yet this is not a problem; it is actually a benefit of the proposal.

There may be an initial tendency for insurance companies to compete for groups of healthy families, to reduce their benefit payouts. But of course that competition, with wide consumer choice, would drive down premiums and profit margins for insurers. So the low-risk portion of the market might not in fact be particularly attractive for insurers. The conventional wisdom is that insurers would not be interested in high-risk families, because high benefit payouts would mean high premiums that families would not be able to pay. This certainly is the case today, given the tax treatment of individual and non-company group insurance. But under the Heritage proposal, the government would give generous refundable tax credits to families facing high premiums or out-of-pocket expenses. And since the higher-risk family thus would be able to afford the higher premiums needed to provide extra services, that part of the insurance market would be just as attractive to insurers as the low-risk (but low premium) family.

Specialized Plans. It is also very likely that insurers and hospitals under the Heritage proposal would develop special health plans, including insurance and specialized medical services, for Americans with chronic medical problems, such as diabetics, the handicapped, the mentally ill, and cancer sufferers. These plans would be far better products for these special-needs Americans than the typical "one-size-fits-all-employees" company plans. Most such plans no doubt would be expensive, but some would be able to keep costs down by substituting special services in place of other services not used by most of the group. Example: older diabetics probably would have a plan without pregnancy benefits. Patients under such plans would have tax credits to offset the extra costs. If a family today has to obtain special services not provided under the employer's plan, it must usually do so without any tax relief. Consumer-driven competition would be just as strong among these high-cost

plans as among low-benefit plans for the healthy, assuring good value for money.

Cross-subsidization thus would occur under the Heritage proposal. Under today's health care system, virtually the only way that Americans needing medical care are subsidized is through equal premiums for all workers in a company group. Healthy families subsidize less healthy families because all pay the same premium while using very different quantities of medical services.

One problem with this is that employers, particularly small firms, are understandably unenthusiastic about hiring a new worker who may incur unusually high medical bills, since the company's insurer eventually will raise the group's premium if usage increases. Under the Heritage proposal, most cross-subsidization would occur through the tax system, not through premiums, so the problems now facing insurers – and less healthy Americans seeking work – would disappear. Moreover, subsidizing through the tax code is a far more precise and efficient method than the imprecise cross-subsidization achieved through equal premiums in company plans.

4)But if the government provides generous credits for expensive insurance and treatment, wouldn't that increase the tax revenue losses to government and encourage Americans to buy extra, but unnecessary coverage?

Tax revenue losses would indeed be relatively high for credits provided to an unhealthy family needing expensive insurance. On the other hand, the losses would be sharply reduced on insurance and medical care purchases by healthy Americans.

But total revenue losses on average would be lower under the Heritage proposal than under current tax law for three reasons. First, the increased consumer sensitivity to cost would slow general medical costs, and hence tax losses on medical insurance purchases. Second, healthy families no longer would have the incentive to overuse medical services, again reducing tax losses. Although the Heritage proposal does not envision a cap on the total amount of insurance or services eligible for credit, families would still have to contribute toward the cost. Although the credit would encourage a certain amount of over use, it would almost certainly be a less than is common today under company-paid plans. And third, even though millions of additional families would be eligible for tax relief, or refunds, this would cost the government less than it does today when most of these families turn to Medicaid or receive uncompensated medical care with the cost usually added to the medical bills of patients with tax-free company insurance.

5)Most Americans today have their medical insurance premiums paid directly by their employer, and they do not have to worry about claiming back tax relief. Wouldn't the Heritage proposal lead to many Americans not buying insurance, or missing premium payments, and wouldn't lower-paid workers be unable to wait until the end of the tax year for their credits?

Under the Heritage proposal, it would be illegal not to buy basic catastrophic insurance, and credits would be available only for actual purchases of insurance or medical care during the tax year. When tax returns were filed, the family would receive a "proof of insurance" form from its health insurance company, much like a W-2 form, and this would have to be appended to the return. This form would indicate the cost of insurance, and certify that at least the legal minimum is bought. If the proof of insurance forms were not attached, or did not indicate that the family was insured throughout the year, a financial penalty would be imposed.

The problem of workers avoiding this requirement in the first place, or finding themselves unable to make payments, would be eliminated in most cases through a modest book-keeping requirement for employers. The tax credit available under the Heritage plan would be blended into the tax withholding system for employees. Thus a worker would claim adjustments based on his family's anticipated insurance and out-of pocket expenses (just as he does today, based on such factors as the size of his family, and his mortgage interest payments), and withholding would be adjusted accordingly. If medical and insurance costs begin to run higher than expected, the withholding amount could be changed. Similarly, if the worker is entitled to a refundable credit, meaning that the credit exceeded his or her normal tax liability, a monthly amount would be added to the paycheck by the employer, and deducted from the total tax withholdings sent by the employer to the IRS. At the end of the year, of course, the family would complete a 1040 tax form, including actual medical expenses that year, and the taxes would be adjusted.

In addition, employers could be required to take a deduction from each employee's paycheck to pay for health insurance, and send a check to the health insurance company of the worker's choice – much as many employers today deduct voluntary contributions for 401(k) pension plans. The amount of the check would depend on the insurance package chosen by the worker. Thus the employer would not pay the premium, but would assure that it was paid.

6)Why would a worker with a generous company health benefits package have any reason to support the Heritage proposal?

Workers in some industries have very generous health benefits. For instance, automobile workers typically have approximately $3,000 in tax-free employer-paid health benefits.[6] They, however, would accept a credit proposal that probably would give them less total tax relief for several reasons. First, if they had the choice, many workers would accept less in benefits if they could have more in cash, even taxable cash. The Heritage proposal allows them to make that choice. Second, they could choose the benefits they

6 Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Employees* (Dallas, Texas: National Center for Policy Analysis, 1990), p. 5.

want, rather than the company-provided benefits. Under the Heritage proposal, workers could increase coverage or spending for certain services they want or need, such as better coverage for a child, while perhaps reducing others, and obtain the same tax relief. Third, if a worker moves to another job, his coverage would not have to change. And fourth, the worker would not have to face pressure to reduce benefits by financially-strapped employers, a common problem in some industries today.

7)What does the Heritage proposal do for the very poor?

The Heritage proposal's incentives to reduce medical cost inflation through more active consumer choice would benefit the poor by tapering general medical costs. In addition, the proposal would grant refundable tax credits for health insurance and services to workers in those firms unable to offer health insurance. This would be particularly beneficial to low-paid workers in small firms. It would also make employment more attractive to many Americans now on welfare who are reluctant to leave the rolls because their Medicaid benefits are phased out and often they do not have health insurance provided by their new employer.

Medicaid for the very poor would be retained under the Heritage proposal, and the plan contains recommendations for reforming the program.[7] Besides these reforms, aimed at encouraging more state experimentation in alternative delivery arrangements and promoting state-subsidized risk pools for difficult-to-insure Americans, the proposal would permit states to enroll welfare recipients in the competitively-priced private health plans emerging under the new tax incentives for working Americans. That would enable states and the federal government to achieve savings that could be used for new services or for deficit reduction.

8)Isn't the Heritage proposal too radical to be adopted by Congress?

The Heritage proposal would lead to a radical change in America's health care system. But so would the introduction of a Canadian-style system, or a system in which employers operated a nationwide comprehensive system. Lawmakers and policymakers now recognize the need for radical reform.

An understandable worry about the Heritage proposal is that it has never been tried on a large scale – although modest individual deductions are available under the tax code for some Americans. But an advantage of the proposal is that it could be introduced gradually, so that it could be tested and so that Americans would have the opportunity to become familiar with its key elements before a complete transition. Thus although the proposal would constitute a major reform of America's health care system – and only fundamen-

7 Terree P. Wasley, "Health Care For The Poor, Unemployed, and High Risk," in Butler and Haislmaier, *op. cit.*, pp. 91-119.

tal reform will address the system deep problems – it could be introduced in stages.

Beginning Step. Moreover, Congress is poised to take the first step in creating a system of credits for health purchases. A provision in the Senate-passed version of the child care legislation (S.5), in fact, would be a significant step toward enacting the Heritage plan. Authored by Senator Lloyd Bentsen, the Texas Democrat who chairs the Finance Committee, the measure would grant a 50 percent tax credit to low-income families for the purchase of insurance for children not covered under a company plan. If this becomes law, it would introduce the concept of an individual tax credit for health care.

The next step would be to establish a refundable credit for all dependents not covered under company plans, not just children, recouping the revenue loss by placing a ceiling on the value of a company-based plan that would be free of tax. The third step would be legislation to phase out entirely the tax exclusion for company plans and to introduce the full individual credit.

Senator William Cohen, the Maine Republican, has introduced a bill (S. 2032) that would accomplish some of these steps. The bipartisan bill is cosponsored by such Democrats as David Boren of Oklahoma and Sam Nunn of Georgia. The Cohen legislation would establish a refundable credit of up to 60 percent of yearly health insurance expenses for low- and moderate-income families without company-provided plans. The legislation would not, however, reform the tax treatment of employer-provided insurance.

CONCLUSION

Americans are less satisfied with their health care system than are the citizens of most major industrialized countries. Their dissatisfaction is understandable. The American system may deliver the world's best medicine, but millions lack adequate coverage, the cost of care is skyrocketing, and even those with good insurance often are anxious about many features of their coverage.

The Heritage proposal addresses the central deficiencies of the current system. By changing the tax treatment of health care spending, it would introduce powerful incentives to control costs and make it possible for those currently without adequate insurance to afford protection. It would create a consumer-driven and market-based national health system for America, without the heavy regulation or explosive costs of the other major proposals now being examined by Congress.

Stuart M. Butler, Ph. D.
Director of Domestic Policy Studies

Posted at 3:20 PM ET, 02/ 1/2011

An interview with Mark Pauly, father of the individual mandate

By Ezra Klein

In 1991, economist Mark Pauly was the lead author of a Health Affairs paper attempting to persuade President George H.W. Bush and his administration to adopt a universal health-care proposal that would keep the government from eventually taking over the sector. "Our view is that excessive government intervention will make matters worse," wrote Pauly and his co-authors. "Our strategy, therefore, is to design a scheme that limits governmental rules and incentives to the extent necessary to achieve the objectives."

At the heart of that strategy was the individual mandate, which would go on to be promoted by congressional Republicans, the Heritage Foundation, and Massachusetts Gov. Mitt Romney before being adopted by Democrats and becoming a bete noire of conservatives. I spoke to Pauly earlier this afternoon, and an edited transcript of our conversation follows.

Tell me about your involvement in the development of the individual mandate.

I was involved in developing a plan for the George H.W. Bush administration. I wasn't a member of the administration, but part of a team of academics who believe the administration needed good proposals to look at. We did it because we were concerned about the specter of single payer insurance, which isn't market-oriented, and we didn't think was a good idea. One feature was the individual mandate. The purpose of it was to round up the stragglers who wouldn't be brought in by subsidies. We weren't focused on bringing in high risks, which is what they're focused on now. We published the plan in Health Affairs in 1991. The Heritage Foundation was working on something similar at the time.

What was the reaction like after you released it?

There was some interest from Republicans. I don't recall whether they formally wrote a bill or just floated it as an idea *[It did make it into a bill -- Ezra]*, but Democrats in Congress said it was "dead on arrival." So that was the end of my 15 minutes.

Was the constitutionality of the provision a question, either in your deliberations or after it was released?

I don't remember that being raised at all. The way it was viewed by the Congressional Budget Office in 1994 was, effectively, as a tax. You either paid the tax and got insurance that way or went and got it another way. So I've been surprised at that argument. But I'm not an expert on the Constitution. My fix would be to simply say raise everyone's taxes by what a health insurance policy would cost -- Congress definitely has the power to do that -- and then tell people that if they obtain insurance, they'll get a tax break of the same amount. So instead of a penalty, it's a perfectly legal tax break. But this seems to me to angelic pinhead density arguments about whether it's a payment to do something or not to do something.

That gets to one of the central questions in this argument, which is whether the individual mandate is a penalty for economic inactivity or whether it's part of a broader system of regulations affecting a market for health care that we're all participating in, whether we're buying insurance that day or not.

I see it in the latter way. We thought it was a good idea to do everything possible to encourage people to get insurance. Subsidies will probably pick up the great bulk of the population. But the point of the mandate was that there are a few Evil Knievals who won't buy it and this would bring them into the system. In our version, the penalty was effectively equal to the premium of a policy. You paid the penalty and you got the insurance. That's one of my puzzlements here: In the new law, the actual level of the penalty is quite small compared to the price of a policy. It's only about 20 percent of the cost of a policy.

Do you think the mandate is severable from the larger bill?

I think you could do that. I'd want to take some other things out of the bill, too. But the main part I favor and the part that deals with the uninsured are these subsidies for lower-middle-income people. The great bulk of them would take insurance with those breaks. That won't go away. The mandate props up community rating, which I'm not a fan of. So I'd throw overboard both the mandate and the community rating. Then I'd add high-risk pools.

You say the mandate was developed as a way to avoid single-payer health care. As I see the evolution of this issue, Richard Nixon countered single-payer with an employer mandate, then Clinton co-opted the employer mandate and Republicans moved to an individual mandate, and then Obama co-opted the individual mandate. But there's nowhere else to go, as far as I can tell. If the individual mandate dies, it seems to me that the eventual universal coverage solution will rely heavily on government programs -- we'll have single payer in fact even if we don't have it in name.

I think there's a slippery slope in that direction. I have mixed feelings about the mechanics of the current bill. Our idea was to have tax credits and very little additional government control over insurance markets, and the legislation has an awful lot of that. I believe you could achieve almost the same reduction of the uninsured with the subsidies and without the mandate. But CBO says that you leave about 40 percent of the uninsured population

'RomneyCare' Facts and Falsehoods

We take a look at Massachusetts' health care law, before the 2012 campaign claims really start flying.

Posted on March 25, 2011

Summary

BOSTON — It has been nearly five years since Massachusetts Gov. Mitt Romney signed the state's landmark health care law amid the political flourish of a fife and drum corps and 300 guests in Boston's Faneuil Hall. The overhaul is largely seen as a blueprint for the sweeping federal legislation that followed, making the state a political target for critics of President Obama's efforts.

Brian Rosman, research director for the advocacy group Health Care for All, still has his ticket from Romney's signing displayed in his downtown office. Obviously, Rosman's group is pleased that the state has tried to cover as many of the uninsured as possible. But the law passed with support from a wide range of stakeholders.

Massachusetts' game plan shares several characteristics of the national legislation, but there are differences, including one major distinction: The level of vitriol directed at the federal law doesn't exist here. Sure, there are criticisms and compromises, disagreements and disappointments — but they come with a distinct lack of the death-panel-type furor that rose up against the law Obama pushed.

Even the fiscally conservative, but nonpartisan, Massachusetts Taxpayers Foundation is on board. President Michael J. Widmer calls the law "a well thought-out piece of legislation" that his group supported because, "we believe in public investments." Widmer says: "There have been critics from the left and the right ... that have not wanted the Massachusetts experiment ... to succeed from the outset for different reasons. Most of those critics are either out of state," or academics or single-payer advocates. "And then, of course, you get the politicians on top of that."

Yes, the politicians. The Massachusetts plan has been attacked by opponents of the national law, liberal advocates of Canadian-style single-payer insurance for all, and conservative Republicans hoping to derail Romney's presidential aspirations. For example, former Arkansas Gov. Mike Huckabee, in a February interview with the Associated Press, said Romney should essentially apologize for the law and acknowledge that it "cost more, waiting times were higher, quality of care went down, people were greatly dissatisfied and it ended up having almost the polar opposite effect of what was intended." We found that there's not much truth in any of that.

As the 2012 presidential campaign gets under way in just a few months (believe it or not), we expect to see an increasing number of attacks on so-called "RomneyCare." So as part primer and part preemptive fact-checking, this article is our attempt to set the record straight. We found:

- The major components of the state and federal law are similar, but details vary. The federal law put a greater emphasis on cost-control measures, for instance. Massachusetts is just now tackling that.
- The state law was successful on one big goal: A little more than 98 percent of state residents now have insurance.
- Claims that the law is "bankrupting" the state are greatly exaggerated. Costs rose more quickly than expected in the first few years, but are now in line with what the Massachusetts Taxpayers Foundation had estimated.
- Small-business owners are perhaps the least happy stakeholders. Cheaper health plans for them through the state exchange haven't materialized, as they hoped.
- Despite claims to the contrary, there's no clear evidence that the law had an adverse effect on waiting times. In fact, 62 percent of physicians say it didn't.
- Public support has been high. One poll found that 68.5 percent of nonelderly adults supported the law in 2006; 67 percent still do.

Massachusetts Taxpayers Foundation

Massachusetts Health Reform: The Myth of Uncontrolled Costs

MAY 2009

MTF

MASSACHUSETTS HEALTH REFORM: THE MYTH OF UNCONTROLLED COSTS

Table of Contents

MASSACHUSETTS HEALTH REFORM: THE MYTH OF UNCONTROLLED COSTS

Overview

Three years after Massachusetts enacted its groundbreaking health care reform law, Chapter 58 of the Acts of 2006, the number of residents with health insurance has increased by more than 432,000, giving the Commonwealth by far the lowest rate of uninsured residents in the nation.

An analysis by the Massachusetts Taxpayers Foundation finds that the cost of this achievement has been relatively modest and well within early projections of how much the state would have to spend to implement reform.

Based on actual and projected spending data for the first four years of health care reform, the Foundation concludes that state budget spending on health reform has grown from a base of $1.041 billion in fiscal 2006 to a projected $1.748 billion in fiscal 2010. That is an increase of $707 million, half of which is supported by federal reimbursements. The $353 million state share translates into an average yearly increase of only $88 million (see Table 2, p.6).

How has Massachusetts been able to reduce the number of uninsured to less than three percent of its population while spending so few new public dollars? To a large degree, the answer can be found in the unique way the law's programs and incentives act in concert to expand access to subsidized coverage for low-income adults and children largely through a reallocation of funds from uncompensated care, while also encouraging enrollment in employer-sponsored and individual health insurance plans.

This "shared participation" approach to reform was instrumental in solidifying support for Chapter 58 from a broad spectrum of stakeholders, including hospitals, physicians, insurers, employers, unions and community groups, and it has helped keep the support solidly intact despite occasional but significant disagreements over some aspects of implementation.

Table 1 - Changes in the Massachusetts Insured Population Since the Implementation of Health Care Reform (rounded to the nearest 1,000)

Type of Insurance	6/30/2006	12/31/2006	6/30/2007	12/31/2007	6/30/2008	9/30/2008	Change since 06/30/06
Employer Group	4,292,000	4,356,000	4,396,000	4,422,000	4,431,000	4,440,000	148,000
Individual Purchase	40,000	39,000	36,000	65,000	76,000	79,000	39,000
Commonwealth Care	0	18,000	80,000	158,000	176,000	169,000	169,000
MassHealth	705,000	741,000	732,000	765,000	785,000	781,000	76,000
Total Members	5,037,000	5,154,000	5,244,000	5,410,000	5,468,000	5,469,000	432,000

Source: Massachusetts Division of Health Care Finance and Policy, *Health Care in Massachusetts: Key Indicators Report*, February 2009

Setting the stage for health care reform

While groundbreaking in its scope, the Massachusetts health care reform law evolved from a series of earlier reforms designed to ensure that all residents would have access to necessary medical care, regardless of income or health insurance status.

In 1985, the Commonwealth created an "uncompensated care pool" to reimburse acute care hospitals and community health centers for a portion of the costs of caring for low-income uninsured patients who did not qualify for Medicaid or other public programs. The pool was funded by a combination of federal and state dollars, assessments on the state's hospitals, and a surcharge on payments to acute hospitals and ambulatory surgery centers. For the most part, the cost of the provider surcharge was passed through to the employer community in the form of increased health insurance premiums.

Just over a decade later, Massachusetts was granted a federal "Medicaid waiver," giving the state added flexibility in the way it could spend Medicaid dollars. (Massachusetts receives a 50-50 match from the federal government for the state's Medicaid spending.) Massachusetts used its initial waiver authority to enroll eligible adults and children in private Medicaid Managed Care Organizations (MMCOs) through MassHealth, which includes both Medicaid and the State Children's Health Insurance Program (SCHIP). MassHealth members receive comprehensive medical benefits at little or no cost.

Together, uncompensated care and MassHealth represented a major public investment in meeting the health care needs of low-income residents. In FY06, the state fiscal year before health care reform was implemented, the price tag for uncompensated care reached $656 million and federal funding for Medicaid Managed Care Organizations totaled $385 million.

A key goal of health care reform was to minimize the need for new state spending by reallocating existing funds from uncompensated care to subsidized, private coverage for low-income, uninsured residents. Using estimates of the number of low-income uninsured residents in various income categories and the number of low- and moderate-income people receiving uncompensated care, policymakers projected that the cost of uncompensated care would decline as state subsidies for public insurance programs increased.

In 2006, the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth reached agreement on an extension of the Medicaid waiver that gave the state the flexibility and continued federal funding it needed to accomplish this goal. A framework was now in place to achieve nearly universal health care coverage in Massachusetts by expanding both public and private insurance.

Early growth in subsidized care raised red flags

The centerpiece of health care reform on the public side is Commonwealth Care, a state-run subsidized insurance program for low- and moderate-income residents who are ineligible for MassHealth and who cannot otherwise afford coverage. Commonwealth Care members receive their coverage through private Medicaid Managed Care Organizations and their premium subsidies are based on family income.

Enrollment in Commonwealth Care had reached 80,000 members by the end of FY07, the first full year of health care reform, and six months later that number had almost doubled to 158,000, raising concerns that there were many more low-income uninsured residents than had been estimated. Anticipating that Commonwealth Care would continue to grow at a rapid pace, the Patrick administration projected that total state and federal spending for Commonwealth Care would jump to $1.09 billion in FY08 and $1.32 billion in FY09. In the eyes of some critics, this was evidence that Massachusetts health care reform was proving to be unaffordable.

As it turned out, however, the initial sharp climb in enrollment was not a sign that the state had grossly under-counted the uninsured population; rather, it was a function of the extraordinary success in enrolling individuals much faster than had been anticipated. Through a coordinated effort by several state agencies, the state had automatically enrolled tens of thousands of eligible individuals who had been receiving uncompensated care and many more were enrolled through a massive outreach program conducted by community agencies and by the state itself.

Instead of continuing its rapid growth, Commonwealth Care enrollment peaked at 176,000 members in mid-2008 and spending has since declined. In fact, as Massachusetts faces a budget crisis of historic proportions, Commonwealth Care is expected to spend at least $69 million less than its $869 million appropriation for FY09. The surplus will be carried forward in the Commonwealth Care Trust Fund, reducing the amount that will have to be appropriated for health care reform in FY10.

Calculating the public cost of health care reform

Using actual and projected spending data for the first four years of implementation, the Foundation has analyzed increases and decreases in each of the major spending categories that comprise health care reform. The analysis, summarized below and in Table 2, finds that new spending for Commonwealth Care and MassHealth was largely offset by decreases in uncompensated care pool payments and in supplemental payments to Medicaid Managed Care Organizations.

New Spending Under Health Care Reform: Commonwealth Care and MassHealth

As discussed above, fears that Commonwealth Care spending would reach $1.32 billion by FY09 proved to be unwarranted. Current estimates place the actual price tag for FY09 at $800 million and project FY10 spending of $880 million.[1] While this is "new" spending, most of it is effectively offset by a shift in funding from institutional support to support for individuals' health coverage.

The second major area of new public spending under health care reform is related to MassHealth. Prior to reform, MassHealth was providing full coverage to more than 700,000 state residents, but there were gaps in eligibility and coverage for certain categories of low-income and disabled individuals. Chapter 58 closed these gaps by expanding MassHealth eligibility for children, the long-term unemployed, legal immigrants, people living with HIV, children and working adults with

[1] The $880 million, which is used in this report, is an administration estimate and is also included in the House budget. Because of proposed cutbacks in eligibility for some categories, the Senate Ways and Means budget is reduced by $140 million.

disabilities, and small businesses with low-income employees. It also restored a number of MassHealth benefits that had been cut four years earlier.

In addition, Chapter 58 mandated substantial Medicaid rate increases to hospitals and physicians who had been underpaid for years. However, the Governor's mid-year budget cuts in FY09 effectively eliminated the increases, so they are not included in the spending for FY09 and FY10.

In total, the MassHealth provisions of health care reform will cost an additional $487 million in FY10.

Reduced Spending Under Health Care Reform: Uncompensated Care and Payments to Medicaid MCOs

The Massachusetts Uncompensated Care Pool was replaced by the Health Safety Net on October 1, 2007, and the state implemented new eligibility rules and benefits. With Commonwealth Care and MassHealth eligibility and benefit expansions in place, and with the state's requirement that residents maintain insurance coverage if it is affordable, the number of people eligible for uncompensated care has fallen significantly. As a result, the Health Safety Net is expected to spend $381 million in FY10, $275 million less than the amount spent on uncompensated care before health care reform.

The supplemental Medicaid MCO payments that had been used to support the state's two major safety net hospitals, Boston Medical Center and Cambridge Health Alliance, were eliminated under health reform, and this $385 million in federal spending was shifted into expanded coverage for low-income, previously uninsured individuals.

Finally, recognizing that the Boston Medical Center and Cambridge Health Alliance would continue to need financial support during the transition to Commonwealth Care, the drafters of Chapter 58 authorized new supplemental payments – known as "Section 122" payments – for three years starting in FY07. These special payments end in FY09 so there is no net increase in annual spending from FY06 to FY10 in this category.

Overall, the projected increase in spending for Commonwealth Care and MassHealth expansions from FY06 to FY10 is $1.367 billion, and the net decrease in spending for uncompensated care and Medicaid MCO payments is $660 million. This yields a net increase in health care reform spending in fiscal year 2010 of $707 million, with the state's share $353 million, an average annual increase of just $88 million.

Table 2 - Health Care Reform Spending FY06-FY10
($ millions, projections as of May 2009)

	FY06 Actuals	FY07 Actuals	FY08 Actuals	FY09 Estimated Spending	FY10 Projected	Change FY06-FY10
Commonwealth Care	0	133	628	800	880	880
MassHealth Coverage Expansions, Rate Increases and Benefit Restorations	0	224	355	452	487	487
Uncompensated Care Pool/Health Safety Net Trust Fund	656	665	416	406	381	-275
Supplemental Payments to Medicaid MCOs (federal share)	385	0	0	0	0	-385
Supplemental Payments to Safety Net Hospitals	0	287	287	200	0	0
Total	**1,041**	**1,309**	**1,686**	**1,858**	**1,748**	**707**
State Share of FY06-FY10 Increase in Spending						**353**

Source: MTF analysis of Patrick administration data. Massachusetts receives 50 percent in matching funds from the federal government for the state's Medicaid spending, which includes all waiver-related spending.

Revenue sources are earmarked for health care reform

While the Commonwealth faces a grave budget crisis brought on by a collapse in tax revenues, it is important to note that the state has identified various revenue sources to cover much of the increase in health reform spending. A $1 per pack increase in the state cigarette tax is expected to generate $160 million for health reform in FY09 and $145 million in FY10, and a "one-time assessment" on health care providers and insurers will produce $53 million in FY09.

Other revenue sources that were built into Chapter 58 include a continuation of the annual $320 million uncompensated care contribution from the private sector to the Health Safety Net Trust Fund; individual tax penalties assessed on Massachusetts residents who do not meet the requirements for maintaining coverage, projected at $12 million in FY09 and FY10; and the employer fair share assessment, projected at $12 million in FY09 and $20 million in FY10.

In March 2009, the Patrick administration proposed using $40 million of federal stimulus funds for acute hospital rate increases in FY10 and $120 million to continue supplemental payments to Boston Medical Center and Cambridge Health Alliance in FY10, but given the state's fiscal crisis these payments are not expected to take place.

Private health care coverage accounts for almost half of the newly insured

The dramatic increase in insured residents that has resulted from the introduction of Commonwealth Care and the expansion of MassHealth is only one aspect of the health care reform success story in Massachusetts. Another hallmark of Chapter 58 is its use of individual and employer incentives and responsibilities to build on the state's historically high level of employer-sponsored coverage.

Almost 90 percent of the Massachusetts businesses that are subject to the health care reform law – those with more than 10 full-time-equivalent employees – offer health insurance to their employees. Yet, prior to health care reform, there were tens of thousands of workers in the state who chose not to accept employer-sponsored coverage.

The individual mandate provisions of Chapter 58 require Massachusetts residents to maintain adequate, "creditable" health insurance or be subject to tax penalties unless no "affordable" option is available to them. (The standards for creditable coverage and affordability are determined by the Commonwealth Health Insurance Connector Authority and its public-private board of directors.) With this requirement in place, employer-sponsored enrollment has increased by 148,000 and the number of individuals buying private coverage directly has grown by 39,000 (Table 1).

Strong, steady growth in privately funded coverage has helped dispel concerns that public programs would replace, or "crowd out," private coverage. In fact, the Foundation estimates that the added cost to Massachusetts employers for newly insured employees and dependents is at least $750 million – more than double the $353 million increase in state spending since health reform was enacted.

Conclusion

Massachusetts broke new ground with its approach to health care reform, and thus far the underlying financial model of shared participation is working well, with major strides in reducing the size of the uninsured population and only a marginal impact on state spending.